Appropriations Committee; and we are finished with those and will bring them to the floor. We have gotten permission to go to the conference committee on terrorism, which we have been trying to do for weeks. There was significant progress made today with passage of the bankruptcy conference report, and there were other things.

But finally, what I want to say, we will shortly approve in a matter of a few minutes, four members to the Securities and Exchange Commission. That goes hand and glove with the work we have done on corporate governance. We are going to approve Cynthia Glassman to be a member, Harvey Jerome Goldschmid to be a member, Roel C. Campos to be a member of the Securities and Exchange Commission, and Paul S. Atkins will also be approved. We have had a very successful day.

For those watching, whether it is staff or people around the country, sometimes during the downtimes a lot of progress is made. Even as we speak, there is work being done to see if we can come up with a bipartisan amendment to handle the prescription drug problems that senior citizens have in America today. All in all, it was a good day for the country.

I ask unanimous consent that immediately following the cloture vote tomorrow, Friday, the Senate proceed to executive session to consider Executive Calendar No. 826, Christopher C. Conner to be United States district judge; that the Senate vote immediately on confirmation of the nomination, the motion to reconsider be laid upon the table, and any statements be printed at the appropriate place; that the President be immediately notified of the Senate's action, the Senate return to legislative session, and that the proceeding all occur without any intervening action or debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

MORNING BUSINESS

Mr. REED. I ask unanimous consent that we now proceed to a period of morning business with Senators allowed to speak for not to exceed 5 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

MEDICARE PRESCRIPTION DRUG COVERAGE

Mr. SARBANES. Madam President, I rise to express my disappointment about the outcome of the Senate's recent vote on Medicare prescription drug coverage. The Senate missed an opportunity to provide one of the most important expansions of Medicare benefits since the system was created in 1965. Senator GRAHAM's proposal, of which I was proud to be an original cosponsor with a number of my Democratic colleagues, would have provided comprehensive, voluntary, and affordable prescription drug coverage for all Medicare beneficiaries. Though the majority of the Senate supported this proposal, it lacked the votes necessary to proceed.

We know that more than 1 in 3 Medicare beneficiaries lack prescription drug coverage. We know, too, many seniors struggle to pay for the medicine they need to keep them healthy and treat their diseases and illnesses. We know that doctors are now put in the unthinkable position of considering a patient's financial situation when developing a course of treatment. Doctors are conflicted by this, but know that it does not benefit the patient to prescribe a drug, even though it may be the best method of treating or curing an illness, if the patient cannot afford the medicine.

More importantly, I, like most of my colleagues, continually hear from constituents who face this dilemma directly. They are ill, they are frustrated, and too many times, they are embarrassed to have made it this far in life and have to ask for help after years of independence. I have heard from those who may not have a direct need, but who are desperately seeking assistance for a loved one who needs help. They are frustrated to learn that there is nowhere for them to turn because Medicare provides nothing for outpatient drugs, yet they have too much income or too many assets to qualify for state offered assistance.

The Graham proposal would provide drug coverage for all Medicare beneficiaries for a $25 monthly premium, no deductible, a $10 copayment for generic drugs, and a $40 copayment for preferred brand name drugs. In addition, Medicare beneficiaries would have all of their prescription costs covered after they spend $4,000 in out-of-pocket costs. Assistance would begin with the very first prescription, and there would be no gaps or limits on the coverage provided. Under Senator GRAHAM's proposal, low-income seniors would not be required to pay premiums or copayments for their coverage.

Regrettably, some of my colleagues did not support the Graham amendment. They voted instead for an alternative that required seniors to pay a $250 deductible, while only covering 50 percent of their prescription costs up to $3450. After a Medicare beneficiary's costs exceed $3450, he or she would receive no assistance whatsoever until his or her costs reach $3700. Above $3700, the government would then only pay 90 percent of drug costs. Under this proposal, those who are the sickest, with the highest drug costs, would be forced to pay more when they require assistance the most.

Many of those who opposed the Graham proposal complained about the cost of this proposal. I find it perplexing that we can find money for other things, but not for the mothers, fathers, grandparents and other Americans that need our help in their older years. Opponents of the Graham bill found money to fund a large tax cut costing $1.35 trillion last year a tax cut that primarily benefit the very wealthiest Americans. Many of my fears about the decision to pass such a large and unreasonable tax cut have been realized raids on Social Security and Medicare, a return to budget deficits, instability in the financial markets. It has forced us unnecessarily to limit resources for those things that should be national priorities. I remain astonished that some believe tax cuts should be a priority over providing prescription drug coverage to everyday Americans who have worked hard and paid their taxes all their lives.

Yesterday, we had the chance to mark the 107th Congress with the greatest overhaul of Medicare benefits since its inception 37 years ago. I supported the Graham prescription drug plan along with 51 of my colleagues because I believe it is the only proposal that would provide Medicare beneficiaries with real comprehensive prescription drug coverage. I only hope that we can find a way to enact a meaningful Medicare prescription drug benefit this year. Our older Americans deserve no less.

IMMUNOSUPPRESSIVE DRUG COVERAGE AMENDMENT

Mr. DEWINE. Madam President, I wish to speak to an amendment of mine and my friend and colleague, Senator DURBIN, to help organ transplant patients maintain access to the lifesaving drugs necessary to prevent their immune systems from rejecting their new organs.

Every year, nearly 6,000 people die waiting for an organ transplant. Currently, over 67,000 Americans are waiting for a donor organ. Those individuals who are blessed to receive an organ transplant must take immunosuppressive drugs every day for the life of their transplant. Failure to take these drugs significantly increases the risk of the transplanted organ being rejected.

We need this amendment, because Federal law is compromising the success of organ transplants. Let me explain. Right now, current Medicare policy denies certain transplant patients coverage for the drugs needed to prevent rejection.

Medicare does not pay for anti-rejection drugs for Medicare beneficiaries, who received their transplants prior to becoming a Medicare beneficiary. So, for instance, if a person received a transplant at age 64 through his or her health insurance plan, when that person retires and relies on Medicare for health care coverage, he or she would no longer have immunosuppressive drug coverage.

Medicare only pays for anti-rejection drugs for transplants performed in a Medicare-approved transplant facility. However, many beneficiaries are completely unaware of this fact and how it can jeopardize their future coverage of

immunosuppressive drugs. To receive an organ transplant, a person must be very ill and many are far too ill at the time of transplantation to be researching the complexities of Medicare coverage policy.

End Stage Renal Disease, ESRD, patients qualify for Medicare on the basis of needing dialysis. If End Stage Renal Disease patients receive a kidney transplant, they qualify for Medicare coverage for three years after the transplant. After the three years are up, they lose not only their general Medicare coverage, but also their coverage for immunosuppressive drugs.

The amendment that Senator Durbin and I are introducing today would remove the Medicare limitations and make clear that all Medicare beneficiaries including End Stage Renal Disease patients who have had a transplant and need immunosuppressive drugs to prevent rejection of their transplant, will be covered as long as such anti-rejection drugs are needed.

In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act, Congress eliminated the 36-month time limitation for transplant recipients who: 1. received a Medicare eligible transplant and 2. who are eligible for Medicare based on age or disability. Our amendment would provide the same indefinite coverage to kidney transplant recipients who are not Medicare aged or Medicare disabled.

I urge my colleagues to support this amendment and help those who receive Medicare-eligible transplants gain access to the immunosuppressive drugs they need to live healthy productive lives.

U.S. POLICY ON IRAQ

Mr. FEINGOLD. Madam President, I am pleased to cosponsor S.J. Res 41. As the resolution makes clear, the time is ripe for an open debate on our plans for Iraq.

Some are concerned that an open debate on our policy toward Iraq could expose sensitive intelligence information or that such a debate would tip our hand too much. Others fear that a meaningful debate could back the administration into a corner, and in so doing encourage the administration to adopt a tougher military response.

Ultimately, all of these arguments against an open and honest debate on Iraq could be made with respect to nearly any military decision, and if taken to their extreme, these arguments would challenge the balance of powers in the Constitution by excluding Congress from future war-making decisions. Moreover, to answer some of these concerns more directly, I would also note that the almost daily leaks from the administration on our Iraq policy have tipped our hand even more than responsible congressional hearings and debate would. It is hardly a secret that the United States is considering a range of policy options, including military operations, when it comes to Iraq. And the argument that an open discussion of military action could, in effect, become self-fulfilling is too circular to be credible.

I am concerned with the dangers posed by Saddam Hussein, as well as with the humanitarian situation in Iraq. But I am also very concerned about the constitutional issues at stake here. This may well be one of our last opportunities to preserve the constitutionally mandated role of Congress in making decisions about war and peace.

On April 17, 2002, I chaired a hearing before the Constitution Subcommittee on the application of the War Powers Resolution to our current antiterrorism operations. The focus of that hearing was to explore the limits of the use of force authorization that Congress passed in response to the attacks of September 11. At the hearing, leading constitutional scholars concluded that the use of force resolution for September 11 would not authorize a future military strike against Iraq, unless some additional evidence linking Saddam Hussein directly to the attacks of Sept. 11 came to light. Many of the experts also questioned the dubious assertion that congressional authorization from more than 10 years ago for Desert Storm could somehow lend ongoing authority for a new strike on Iraq.

On June 10, I delivered a speech on the floor of the Senate in which I outlined my findings from the April hearing. As I said then, I have concluded that the Constitution requires the President to seek additional authorization before he can embark on a major new military undertaking in Iraq. I am pleased that S.J. Resolution 41 makes that point in forceful legislative terms.

So this is indeed an appropriate time to consider our policy toward Iraq in more detail. I look forward to hearings that Senator BIDEN will chair before the Foreign Relations Committee. I also look forward to additional debate and discussion on the floor of the Senate, and, when appropriate, in secure settings, where the administration can make its case for a given policy response, and the Congress can ask questions, probe assumptions, and generally exercise the oversight that the American people expect of us.

Through these hearings and debates, it will be important to assess the level of the threat that exists, along with the relative dangers that would be posed by a massive assault on Iraq—dangers that include risks to American soldiers and to our relations with some of our strongest allies in our current anti-terror campaign. And it will be crucially important to think through the aftermath of any military strike.

We don't have to divulge secret information to begin to weigh the risks and opportunities that confront us. But the American people must understand the general nature of the threats, and they must ultimately support any risks that we decide to take to secure a more peaceful future. I don't think the American public has an adequate sense yet of the threats, dangers or options that exist in Iraq. I don't think Congress has an adequate grasp of the issues either. And that is why additional hearings and debates are so necessary.

Finally, I have always said that another military campaign against Iraq may eventually become unavoidable. As a result, I am pleased that S.J. Res 41 is neutral on the need for a military response, while recognizing the intrinsic value of open and honest debate. Following a vigorous debate, if we decide that America's interests require a direct military response to confront Iraqi aggression, such a response would be taken from a constitutionally unified, and inherently stronger, political position. We must also remember that constitutional unity on this question presents a stronger international image of the United States to our friends and foes, and, at the same time, a more comforting image of U.S. power to many of our close allies in the campaign against terrorism.

I am pleased to cosponsor S.J. Res. 41, and I look forward to a vigorous debate on this issue.

PATIENT SAFETY AND QUALITY IMPROVEMENT ACT

Mr. FRIST. Madam President, I rise today to discuss a very critical bill—S. 2590, the ''Patient Safety and Quality Improvement Act.'' This bill, which Senators JEFFORDS, BREAUX, GREGG, and I introduced in May, represents our next step in reducing the number of patients harmed each year by medical errors. Although a variety of patient safety initiatives are underway in the private sector as well as within the Department of Health and Human Services, Congress has an important role to play in reinforcing and assisting these efforts.

Today, the House Ways and Means Committee is expected to report a bipartisan bill—a bill that is almost identical to its Senate counterpart—that will help improve the safety of our health care system. Additionally, President Bush has highlighted the importance of this issue by formally supporting this crucial legislation. Moreover, this bill is supported by over thirty different health care organizations. Mr. President, I will ask that a list of those supporting organizations be included in the RECORD.

As a physician and a scientist, I know the enormous complexities of medicine today and the intricate system in which providers deliver care. I also recognize the need to examine medical errors closely in order to determine where the system has filed the patient. One method used in hospitals is the Mortality and Morbidity Conferences, in which individuals can